Complete Summary

GUIDELINE TITLE

Parent-training/education programmes in the management of children with conduct disorders.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Parent-training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 49 p. (Technology appraisal guidance; no. 102).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Conduct disorders (conduct disorder and oppositional defiant disorder [ODD])

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management

CLINICAL SPECIALTY

Family Practice
Pediatrics

Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

To assess the clinical and cost effectiveness of parent-training programmes in the treatment of conduct disorders

- To examine the clinical effectiveness of parent/training education programmes in terms of their impact on children's behaviour or proxy measures of children's behaviour
- To summarise the available data concerning the cost effectiveness of parent/training education programmes

TARGET POPULATION

Children aged 12 years or younger or with a developmental age of 12 years or younger with conduct disorder

INTERVENTIONS AND PRACTICES CONSIDERED

Parent-training/education programmes (group based, individual, and self-administered)

- Behavioural programmes focusing on parenting skills needed to address the causes of problem behaviours
- Relationship programmes aimed to help parents understand both their own and their child's emotions and behaviour and to improve their communication with the child

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Child behaviour related measures (e.g., the Eyberg Child Behaviour Inventory [ECBI], the Child Behaviour Checklist [CBCL], Parent Daily Reports [PDR], and the Dyadic Parent Child Interaction Coding System [DPICS])
    - Parental mental health outcomes, such as depression, anxiety, stress
- Cost-effectiveness of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the West Midlands Health Technology Assessment Collaboration (WMHTAC), Department of Public Health and Epidemiology, The University of Birmingham. (See the "Availability of Companion Documents" field.)

Methods for Reviewing Effectiveness

Search Strategy

Electronic Databases

Due to the nature of the topic, databases (n=20) from the fields of medicine, social science, and education were searched. Sensitive search strategies were employed in order to identify all potentially relevant studies. Text and Medical Subject Heading (MeSH) words relating to the condition and intervention of interest were combined with filters for randomised controlled trials. There were no language restrictions. Full details of the search strategies can be found in Appendix 4 of the Assessment Report (see the "Availability of Companion Documents" field).

The following electronic databases were searched:

- MEDLINE (Ovid) 1966 to September week 3 2003E
- Excerpta Medica Database (EMBASE) (Ovid) 1980 to 2003 week 38
- Cumulative Index of Nursing and Allied Health Literature (CINAHL) (Ovid) 1982 to September week 3 2003
- Cochrane Central Register of Controlled Trials (CENTRAL) Issue 3 2003
- National Health Service (NHS) Centre for Reviews and Dissemination Health Technology Assessment (HTA) database
- ISI Proceedings (Science and Technology and Social Sciences and Humanities) 1990 to September 2003
- Social Science Citation Index 1981 to September 2003
- International Bibliography of Social Sciences (BIDS) 1966 to September 2003
- Applied Social Sciences Index and Abstracts (ASSIA) 1987 to September 2003
- Educational Resources Information Center (ERIC) (CSA) 1966 to September 2003

- British Education Index (Dialog) 1976 to June 2003
- Australian Education Index (Dialog) 1976 to September 2003
- Sociological Abstracts (CSA) 1963 to September 2003
- Social Sciences Abstracts (CSA) 1980 to September 2003
- PsycINFO 1974 to present (searched 7/10/2003)
- ZETOC (British Library) 1995 to present (searched 7/10/2003)
- Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) databases 1995 to present
- United States (US) National Criminal Justice Reference Service (NCJRS) databases 1970 to September 2003
- Evidence Based Mental Health (EBMH) Online 1998 to October 2003
- Social Care Institute for Excellence's (SCIE's) database (Caredata) was searched using SCIE's enhanced in-house search facility

Ongoing/Unpublished Trials

The National Research Register Issue 3 2003 was searched to identify ongoing and unpublished research. Submissions from manufacturers, professional and patient groups, and commentators were checked, and all parties were contacted with a preliminary list of included studies as an opportunity to highlight any potential omissions.

Citation Searches

Citation lists of systematic reviews (n=16) and included studies (n=34) were checked (although the results of these citation checks have not been included for the peer review version of this report).

Inclusion and Exclusion Criteria

Two reviewers initially scanned all identified citations, and hardcopies of potentially relevant studies were retrieved. Where there was disagreement on whether to retrieve a study, a third reviewer was consulted. An inclusion and exclusion pro-forma (see Appendix 3 of the Assessment Report [refer to the "Availability of Companion Documents" field]) was then used to formally include or exclude the retrieved studies. Two reviewers applied the inclusion and exclusion criteria independently, with disagreements resolved by a third reviewer. Reasons for exclusion were noted. Where there were insufficient details to make a decision, the authors of the study were contacted.

Inclusion Criteria

Study Design: Randomized controlled trials

Population: Parents (or carers) of children or adolescents up to the age of 18 where at least 50% have a behavioural disorder (compulsive disorder [CD], oppositional defiant disorder [ODD], or other more or less severe behavioural problems); no exclusion on the basis of co-morbidities.

Studies were included if:

a. A diagnosis of conduct disorder or oppositional defiant disorder was made using the *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition* (DSM-IV) criteria or similar *OR*
b. If the children were in an elevated or clinical range of a behavioural scale (such as the Eyberg Child Behaviour Inventory [ECBI]) *OR*
c. If the children were described as having behavioural problems, one or more of which would be recognised as being characteristic of conduct disorder or oppositional defiant disorder

Intervention: A parent-training/education programme

a. Where the content is documented and repeatable and which is run over a defined time period
b. Where the treatment focused exclusively on parents only.

There were no restrictions regarding the theoretical basis of a programme, the length, setting, or mode of delivery (e.g., group, individual or self-administered)

Comparator: Any; for example a control group (e.g., waiting list) and/or a different parent-training/education programme and/or a different intervention

Outcomes: At least one measure of child behaviour

Exclusion Criteria

Study Design: Any other study design (e.g., quasi-randomised controlled trials, nonrandomized controlled studies, non-controlled before- and after studies)

Population: Children at risk of a behavioural disorder or children with another disorder only (e.g., Attention Deficit Hyperactivity Disorder [ADHD], learning disabilities) with no evidence that they would fall into one of the categories (a-c) listed under the inclusion criteria

Intervention: A child, family, or teacher focused intervention; a non-structured parent-focused intervention such as a support group or informal home visits; a parent training/education programme in conjunction with another intervention (e.g., a parent training/education programme that also includes children in at least some of the sessions)

Review of Previous Economic/Cost Evaluations of Parent Training/Education Programmes

Search Strategy

A comprehensive search for literature on quality of life in children with conduct disorder and their families, and the costs and cost-effectiveness of parent-training/education programmes was conducted. The following bibliographic databases were searched: Cochrane Library (National Health Service Economic Evaluation Database [NHS EED], and Centre for Reviews and Dissemination databases (Database of Abstracts of Reviews of Effectiveness [DARE]) Issue 3 2003, MEDLINE (Ovid) 1966 to August week 4 2003, EMBASE (Ovid) 1980 to

2003 week 38. The September 2003 issue of the Office of Health Economics Evaluations Database was also searched. Search strategies used are in Appendix 4 of the Assessment Report (see "Availability of Companion Documents" field). Internet sites of national economic units were also interrogated.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

Assessment Report – Systematic Reviews

The Assessment Group identified 16 reviews that assessed the effectiveness of one or more parent-training programmes, using a number of child and parent outcome measures.

Assessment Report – Trials

The Assessment Group identified 25 randomised controlled trials (RCTs) that were relevant to the scope of the appraisal. Trials were included if it appeared likely that 50% or more of the children involved in the study had a conduct disorder or oppositional defiant disorder (ODD) defined by using a standardised screening checklist.

Additional Work

After completion of the Assessment Report, an additional 16 RCTs were appraised, bringing a total of 41 RCTs together in a new report.

Cost Effectiveness

Two published economic evaluations were found; neither was from the United Kingdom (UK) and neither included quality-of-life information. Five costing studies were found that provided estimates of the costs of parent training/education programmes from a UK perspective. Two consultees included costing information in their submissions, although neither was for typical training programmes.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the West Midlands Health Technology Assessment Collaboration (WMHTAC), Department of Public Health and Epidemiology, The University of Birmingham. (See the "Availability of Companion Documents" field.)

Data Extraction Strategy

Studies that met all inclusion criteria were data-extracted by two reviewers using pre-piloted tables. Data relating to quality was independently checked. Data was extracted on main study characteristics (sample source, child characteristics, parent/family characteristics, intervention/comparator(s), outcome measures, size of study, length of intervention, and number of assessments), study quality and results. Outcome data was extracted only for child behaviour related outcome measures. The use of other outcome measures was noted.

Quality Assessment Strategy

In order to evaluate the internal validity of the studies, the following quality criteria relating to selection bias, performance bias, detection bias and attrition bias were assessed (see also quality assessments, Appendix 8 of the Assessment Report [see "Availability of Companion Documents" field]). The appropriateness of the statistical analyses was also assessed.

Selection Bias:

- Method of randomisation (and appropriateness of method)
- Method of concealment of allocation (and appropriateness of method)
- Comparability of treatment groups at beginning of study (demographics, pre-treatment behaviour scores)

Detection Bias:

- Due to the nature of the intervention, individuals administering the intervention cannot be blinded. It was therefore assessed, where applicable, whether outcome assessors were blinded (e.g., for independent observations of child behaviour)

Performance Bias:

- Comparable management of study groups throughout the study (with the exception of the intervention), for example co-interventions, number and nature of assessments

Attrition Bias:

- Loss to follow-up (were all participants accounted for throughout the trial); the risk of attrition bias is likely to increase the greater loss to follow-up is (we used an arbitrary cut-off point of 20%)
- Intention-to-treat analysis (we define an intention-to-treat analysis as the inclusion of all available data into the analysis regardless of compliance with the intervention)
- Sensitivity analysis (defined as inputting a range of missing assessment data in order to investigate how results are altered as a result)

Other Quality Criteria:

- Statistical analyses (were the statistical analyses conducted by the authors clearly detailed and appropriate; if non-appropriate, was the validity of the results/conclusions compromised)
- Selective reporting of results/missing results
- Reporting of *a priori* power calculations

The potential threats to validity in each area of bias (1 selection, 2 performance, 3 detection, 4 attrition, and 5 appropriateness of statistical analysis) were listed for each study in order to estimate the overall quality and to gauge whether a sensitivity analysis should be performed around study quality. Where there were no (or insufficient) details, a conservative approach was adopted and the quality item was assessed as being absent. One point was given where a study failed to meet one or more quality criteria in the 5 areas mentioned above (a maximum 5 points would indicate very poor quality). Where the statistical analysis was only adequate rather than appropriate, 0.5 points were added. Studies with 1 point were classified as 'good' quality, studies with 2 as 'adequate', 3 as 'poor' and 4 as 'very poor'. No attempt was made to weight the various quality criteria. Authors were not contacted for additional information.

Data Analysis and Synthesis

Given the nature of this review, the primary method of data synthesis was qualitative and in the form of detailed tabulation. However, the Assessment Group also undertook a quantitative synthesis of behavioural outcomes across trials. Two approaches were taken: vote-counting and meta-analysis.

1. *Vote Counting*

   All child behaviour related outcome measures were listed for each study, together with the main direction of effect for each outcome (at each assessment point). It was noted where there were statistically significant ($p \leq 0.05$) differences in favour of the intervention (*positive*) or the control (*negative*), or no statistically significant difference (*neutral*). Studies comparing a parent training/education programme to a wait list control have been grouped together as have studies where two or more relevant interventions were compared. All descriptions of the direction of effect refer only to changes between (intervention and control) groups. Changes within groups over time (i.e., pre-and post) have not been described. The Assessment Group excluded results from longer-term follow-up where this is reported for an intervention group only and not for the control group.

2. *Meta-analysis*

   As vote-counting does not take into account the study size and gives no estimate of the effect size or of the uncertainty (confidence intervals) around the estimate, the Assessment Group also performed meta-analysis. Meta-analysis was limited to those outcomes that were reported consistently across a high proportion of trials (i.e. Eyberg Child Behaviour Inventory [ECBI], Child Behaviour Checklist [CBCL], Dyadic Parent-Child Interaction Coding System [DPICS]) and where sufficient outcome data was reported. All meta-analyses were undertaken using a random effects model.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Two published economic evaluations were found; neither was from the United Kingdom (UK) and neither included quality-of-life information. Five costing studies were found that provided estimates of the costs of parent training/education programmes from a UK perspective. Two consultees included costing information in their submissions, although neither was for typical training programmes. The Assessment Group undertook a "bottom-up" costing exercise and used this information to estimate the cost effectiveness of parent-training/education programmes based on assumed quality-of-life gains.

Summary

The analysis undertaken reports the net cost of parent training/education programmes and suggests that for children with conduct disorders, these programmes are cost saving. The vast majority of the cost savings would accrue to the education services and the health services. It was noted that the study used to provide the annual costs falling on the various agencies did not report either on the youth justice service or on potential cost savings for adult healthcare.

The cohort in the study also had an unusually low level of usage and consequently, a low cost to social services. There was no evidence from the trials used in the meta-analysis for a differential effect between group and individual programmes. It was shown that group programmes cost less than individual programmes and therefore these programmes are likely to result in greater cost savings to the various agencies.

See Section 4.2 of the original guideline document for detailed cost-effectiveness information related to the published evaluations, submission evaluations, the

Assessment Group evaluations, and the National Institute for Health and Clinical Excellence (NICE) Decision Support Unit (DSU) economic evaluations.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

This guidance only applies to the management of children aged 12 years or younger or with a developmental age of 12 years or younger.

- Group-based parent-training/education programmes are recommended in the management of children with conduct disorders.
- Individual-based parent-training/education programmes are recommended in the management of children with conduct disorders only in situations where there are particular difficulties in engaging with the parents or a family's needs are too complex to be met by group-based parent-training/education programmes.
- It is recommended that all parent-training/education programmes, whether group- or individual-based, should:
    - Be structured and have a curriculum informed by principles of social-learning theory
    - Include relationship-enhancing strategies
    - Offer a sufficient number of sessions, with an optimum of 8 to 12, to maximise the possible benefits for participants
    - Enable parents to identify their own parenting objectives
    - Incorporate role-play during sessions, as well as homework to be undertaken between sessions, to achieve generalisation of newly rehearsed behaviours to the home situation
    - Be delivered by appropriately trained and skilled facilitators who are supervised, have access to necessary ongoing professional development, and are able to engage in a productive therapeutic alliance with parents

    - Adhere to the programme developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.
- Programmes should demonstrate proven effectiveness. This should be based on evidence from randomised controlled trials or other suitable rigorous evaluation methods undertaken independently.
- Programme providers should also ensure that support is available to enable the participation of parents who might otherwise find it difficult to access these programmes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

The main goals of parent training/education programmes are to enable parents, or the main carer, to improve their relationship with the child and to improve the child's behaviour.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE), which was arrived at after careful consideration of the available evidence. Health and social care professionals are expected to take it fully into account when exercising their judgement. The guidance does not, however, override the individual responsibility of social and healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Notes on the generalisability of the findings: The majority of studies were undertaken in either North America or Australia, and the results may not therefore be generalisable to the United Kingdom (UK). A number of studies that undertook longer term follow-up, albeit uncontrolled, suggest that the benefit in child

behaviour following parent training/education programmes appears to be maintained over time.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in "Standards for better health" issued in July 2004. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by the National Institute for Health and Clinical Excellence (NICE) technology appraisals normally within 3 months from the date that NICE publishes the guidance. Core standard C5 states that healthcare organisations should ensure they conform to NICE technology appraisals.
- "Healthcare Standards for Wales" was issued by the Welsh Assembly Government in May 2005 and provides a framework both for self-assessment by healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales. Standard 12a requires healthcare organisations to ensure that patients and service users are provided with effective treatment and care that conforms to NICE technology appraisal guidance. The Assembly Minister for Health and Social Services issued a Direction in October 2003 which requires Local Health Boards and NHS Trusts to make funding available to enable the implementation of NICE technology appraisal guidance, normally within 3 months.
- NICE has developed tools to help organizations implement this guidance (listed below). These are also available on the NICE Web site (www.nice.org.uk/TA102 [see also the "Availability of Companion Documents" field]).
    - Slides highlighting key messages for local discussion
    - Costing report and costing template to estimate the savings and costs associated with implementation
    - Implementation advice on how to put the guidance into practice and national initiatives which support this locally
    - Audit criteria to monitor local practice (see appendix C in the original guideline document)

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Parent-training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 49 p. (Technology appraisal guidance; no. 102).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Jul

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor A E Ades, MRC Senior Scientist, MRC Health Services Research Collaboration, Department of Social Medicine, University of Bristol; Dr Tom Aslan, General Practitioner, Stockwell, London; Professor David Barnett (*Chair*) Professor of Clinical Pharmacology, University of Leicester; Dr Sheila Bird, MRC Biostatistics Unit, Cambridge; Mrs Elizabeth Brain, Independent

Patient Advocate; Professor Gary Butler, Professor of Paediatrics, University of Reading/Royal Berkshire Hospital; Dr Karl Claxton, Health Economist, University of York; Dr Richard Cookson, Senior Lecturer in Health Economics, School of Medicine Health Policy and Practice, University of East Anglia; Professor Christopher Eccleston, Director Pain Management Unit, University of Bath; Professor Terry Feest, Professor of Clinical Nephrology, Southmead Hospital; Ms Alison Forbes, Lay Representative, Health Consultant Associate, Eden Insight; Professor John Geddes, Professor of Epidemiological Psychiatry, University of Oxford; Mr John Goulston, Director of Finance, St Bartholomew's and the London NHS Trust; Mr Adrian Griffin, Health Outcomes Manager, Johnson & Johnson Medical Ltd; Dr Elizabeth Haxby, Lead Clinician in Clinical Risk Management, Royal Brompton Hospital; Dr Rowan Hillson, Consultant Physician, Diabeticare, The Hillingdon Hospital; Dr Catherine Jackson, Clinical Lecturer in Primary Care Medicine, Alyth Health Centre, Angus, Scotland; Mr Muntzer Mughal, Consultant Surgeon, Lancashire Teaching Hospitals NHS Trust; Ms Judith Paget, Chief Executive, Caerphilly Local Health Board, Wales; Dr Katherine Payne, Health Economist, The North West Genetics Knowledge Park, The University of Manchester; Dr Ann Richardson, Independent Patient Advocate; Mrs Kathryn Roberts, Nurse Practitioner, Hattersley Group Practice, Cheshire; Professor Philip Routledge, Professor of Clinical Pharmacology, College of Medicine, University of Wales, Cardiff; Dr Debbie Stephenson, Head of HTA Strategy, Eli Lilly and Company; Professor Andrew Stevens (*Vice-Chair*) Professor of Public Health, University of Birmingham; Dr Cathryn Thomas, General Practitioner, & Senior Lecturer, Department of Primary Care & General Practice, University of Birmingham; Dr Norman Vetter, Reader, Department of Epidemiology, Statistics and Public Health, College of Medicine, University of Wales, Cardiff; Dr Paul Watson, Medical Director, Essex Strategic Health Authority; Dr David Winfield, Consultant Haematologist, Royal Hallamshire Hospital, Sheffield

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Parent-training/education programmes in the management of children with conduct disorders. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 2 p. (Technology appraisal

102). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

- Costing template and costing report. Parent training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. Various p. (Technology appraisal 102). Available in Portable Document Format (PDF) from the NICE Web site.
- Presenter slides. Parent-training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 22 p. (Technology appraisal 102). Available in Portable Document Format (PDF) from the NICE Web site.
- Implementation advice. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 14 p. (Technology appraisal 102). Available in Portable Document Format (PDF) from the NICE Web site.
- The effectiveness and cost-effectiveness of parent training/education programmes for the treatment of conduct disorder, including oppositional defiant disorder, in children. Assessment report. West Midlands Health Technology Assessment Collaboration (WMHTAC), University of Birmingham. 2004 Apr 1. Electronic copies: Available from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1078. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria can be found in Appendix C of the original guideline document.

PATIENT RESOURCES

The following is available:

- Parent-training/education programmes for managing children with conduct disorders. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 4 p. (Technology appraisal 102).

Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N1079. 11 Strand, London, WC2N 5HR.

NGC STATUS

This NGC summary was completed by ECRI on March 9, 2007.

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